COVENTRY
Health Care of Delaware

Schedule of Payments (Maryland Select)
QHD Open Access $1,200 Deductible

The benefits outlined in this Schedule are in addition to the benefits offered under Coventry Health Care of Delaware, Inc. Small Employer Health Plan and Standard Package Cost Sharing for Maryland Small Employers. The benefits described herein are chosen at the Small Employer's option for an additional Premium to provide lower cost sharing for Members.

	Participating Provider MEMBER RESPONSIBILITY
Contract Year Deductible[1] Individual Family *(Except for covered Well Child Visits and Adult Preventive Care Services described below, there is a combined annual deductible for all Covered services, including prescription drugs.)*	 **$1,200** **$2,400**
Contract Year Out-of-Pocket Limit[2] *(Includes Deductible, Coinsurance, and Copayments)* Individual Family	 **$2,400** **$4,800**
COVERED SERVICES (Deductible applies, as indicated)	
Physician Services Child Well Care and Immunizations – Not subject to the deductible Adult Preventive Care Services – Not subject to the deductible. Eligible expenses include routine physical examinations, routine gynecological examinations, pap smears, routine mammograms, and prostate screening Primary Care Services Specialty Care Services	 $0 Copayment per visit $0 Copayment per visit $20 Copayment per visit after deductible $30 Copayment per visit after deductible
Urgent and Emergency Care Services At an Urgent Care Center At a Hospital Emergency Room (*waived if admitted*) Ambulance *(Coventry Health Care of Delaware, Inc. must be notified within 48 hours of initial treatment in an emergency)*	 $30 Copayment after deductible $100 Copayment after deductible $0 Copayment after deductible
Inpatient Hospital Care Semi-Private Room or Private Room when Medically Necessary • Medications & Drugs • Nursing Care • Intensive / Coronary Care • Radiation Therapy • Administration of Blood • Transplant Services • X-rays and Laboratory • Professional Services	$250 Copayment per admission after deductible
Outpatient Surgery Free-Standing Surgi-Center Outpatient Department of a Hospital	 $30 Copayment after deductible $30 Copayment after deductible

	Participating Provider MEMBER RESPONSIBILITY
Outpatient Laboratory / Outpatient Diagnostic Services X-ray and Ultrasound	$30 Copayment or 50% of the cost of the service, whichever is less, after deductible
Laboratory	$30 Copayment or 50% of the cost of the service, whichever is less, after deductible
Specialized Radiology (including *CAT, MRI, MRA, PET)*	$30 Copayment or 50% of the cost of the service, whichever is less, after deductible
Short-Term Therapies Physical • Speech • Occupational • Respiratory • Cardiac Rehabilitation. *(Short-term Therapies are covered for up to 30 visits for each therapy per condition per Contract Year)*	$30 Copayment after deductible
Habilitative Services For children up to and including the age of 19 years for services including occupational therapy, physical therapy, and speech therapy.	$30 Copayment after deductible
Voluntary Family Planning Infertility Services (after confirmed diagnosis)	50% Coinsurance after deductible
Skilled Nursing Facility Facility, supplies and equipment authorized in lieu of acute care hospitalization within the service area for up to 100 days per Contract Year.	$30 Copayment per day after deductible
Home Health Care Authorized in lieu of acute care hospitalization within the service area.	$0 Copayment after deductible
Hospice	$0 Copayment after deductible
Prosthetic Devices and Durable Medical Equipment (DME) Authorized certain prosthetic devices and durable medical equipment	$0 Copayment after deductible
Chiropractic Services (*Limit of 20 visits per condition per Contract Year*)	$30 Copayment after deductible
Outpatient Mental Health and Substance Abuse Services (Medication Management Visits are not counted towards Outpatient Mental Health Visits)	30% Coinsurance after deductible
Inpatient Mental Health and Substance Abuse Services (2 days of partial hospitalization may be substituted for 1 day of inpatient hospital care)	
Inpatient Hospital Care and Residential Crisis Services (up to 60 days per Contract Year)	$250 Copayment per admission after deductible
Physician Inpatient Services	$20 Copayment after deductible
Prescription Drugs All prescriptions are subject to the same deductible as all other medical services (drugs that require prior authorization are identified in the Formulary with “PA” next to the name of the drug):	

	Participating Provider MEMBER RESPONSIBILITY
Tier 1 or Tier One The group of medications on our Formulary that includes: 1. generic Prescription Drugs that we have designated as Tier One; 2. the select brand name Prescription Drugs that we have designated as Tier One; and 3. non-Prescription Drugs that we have designated as Tier One	Deductible applies, then a $0 copayment per Prescription or refill ($0 copayment per prescription or refill for a 90 consecutive day supply for Maintenance Drugs).
Tier 2 or Tier Two The group of medications on our Formulary that includes: 1. brand name Prescription Drugs we have designated as Tier Two; 2. brand name contraceptives that we have designated as Tier Two; 3. brand name Prescription Drugs that have a narrow therapeutic index (those for which the dose must be monitored through laboratory tests) that we have designated as Tier Two; 4. brands that have newly introduced generics that we have designated as Tier Two; and 5. drugs designated as "DESI drugs" by the U.S. Food and Drug Administration ("FDA") that we have designated as Tier Two. ("DESI drugs" are being reviewed for their effectiveness by the FDA because they were approved solely on the basis of their safety prior to 1962.)	Deductible applies, then the lesser of a $25 copayment per Prescription or refill, or the cost of the drug (Lesser of a $50 copayment per prescription or refill for 90 consecutive day supply for Maintenance Drugs, or the cost of the drug).
Tier 3 or Tier Three Tier Three coverage includes Prescription Drugs that are not otherwise excluded under your Group Contract and that are not designated as Tier One or Tier Two, including brand name and generic Prescription Drugs that are not on our Formulary.	Deductible applies, then the lesser of a $50 copayment per Prescription or refill, or the cost of the drug (Lesser of a $100 copayment per prescription or refill for 90 consecutive day supply for Maintenance Drugs, or the cost of the drug).
Self Administered injectable (other than insulin) *Not available by mail order*	Copay is 50% of the allowable charge not to exceed $75, after the Deductible. The cost-sharing applies to both maintenance and non-maintenance drugs.

Participating Pharmacy Allowable charge means charges for Prescription Drugs dispensed at a Participating Pharmacy that are equal to: the contracted rate or the rate the Health Plan has agreed to pay.
Non-Participating Pharmacy For Prescription Drugs dispensed at a Non-Participating Pharmacy, the allowable charge is calculated as the reasonable cash value of each service.
[1] **Deductible:** Except for In-Network Preventive services, the Deductible must be met before the services listed on this Schedule of Payments will be covered. The individual deductible applies only when the member has employee-only coverage. For policies that include the member and one or more dependents, any number of family members can contribute towards meeting the family deductible amount.
[2] **Out-of-Pocket Limit**: Section 1.9 of the Group Membership Agreement (GMA) is amended to read as follows: The individual Out-of-Pocket Limit is the dollar amount a Member will have to pay out of his or her pocket in a contract year. When a Member has reached the individual Out-of-Pocket Limit, benefits for Covered Services are covered at the rate of 100% for the rest of that contract year. The family Out-of-Pocket Limit is the dollar amount members of the same family will have to pay out-of-pocket in a contract year. When a family has reached the family Out-of-Pocket Limit, benefits for Covered Services are covered at the rate of 100% for the rest of that contract year for all family members. Payments the Member makes due to a denial of benefits are not applied to the Out-of-Pocket Limit. The Out-of-Pocket Limit includes the deductible, copayments, and coinsurance.
[3] To receive In-Network benefits, transplant services must be rendered by a Coventry Transplant Network Provider.

Benefits are administered on a Contract year basis. For Non-Participating Providers, Eligible Charges are based on the lesser of the provider's billed charges or our Out-of-Network Rate, which is defined in your GMA. In addition to your Copayment or Coinsurance, you are responsible for paying Non-Participating Providers the difference between our Out-of-Network Rate and their actual charge for non-emergency services. Your Out-of-Pocket costs for non-emergency care from Non-Participating Providers may be substantial.

This plan is underwritten by Coventry Health Care of Delaware, Inc. Refer to your GMA, applicable Riders, and this Schedule of Payments to determine exact terms, conditions and scope of coverage, including all exclusions and limitations and defined terms.

PLEASE NOTE THAT IF YOU RECEIVE SERVICES FROM AN OUT-OF-NETWORK PROVIDER, YOUR COINSURANCE AMOUNT WILL BE APPLIED TO THE OUT-OF-NETWORK RATE TO DETERMINE HOW MUCH WE PAY FOR COVERED SERVICES PROVIDED BY THE OUT-OF-NETWORK PROVIDER. *Based on your benefit plan, You may have limited coverage for out-of-network services. Please review your group membership agreement carefully regarding when out-of-network services may be included in your coverage.*

Out-of-Network Rate: The Out-of-Network Rate is the rate we pay for claims for services rendered by a non-Participating Provider. We will pay the claims as follows:

- claims submitted by a hospital will be paid at the rate approved by the Health Services Cost Review Commission;
- claims submitted by a trauma physician for trauma care rendered to a trauma patient in a trauma center will be paid at the greater of:
- 140% of the rate paid by the Medicare program, as published by the Centers for Medicare and Medicaid Services, for the same covered service, to a similarly licensed provider; or
- The rate as of January 1, 2001 that the health maintenance organization paid in the same geographic area, as published by the Centers for Medicare and Medicaid Services, for the same covered service, to a similarly licensed provider; and
- Any other health care provider:
- For an evaluation and management service, no less than the greater of:
- 125% of the average rate the health maintenance organization paid as of January 1 of the previous calendar year in the same geographic area, as defined by the Centers for Medicare and Medicaid Services, for the same covered service, to similarly licensed providers under written contract with the health maintenance organization; or
- 140% of the rate paid by Medicare, as published by the Centers for Medicare and Medicaid Services, for the same covered service to a similarly licensed provider in the same geographic area as of August 1, 2008, inflated by the change in the Medicare Economic Index from 2008 to the current year; and
- For a service that is not an evaluation and management service, no less than 125% of the average rate the health maintenance organization paid as of January 1 of the previous calendar year in the same geographic area, as defined by the Centers for Medicare and Medicaid Services, to a similarly licensed provider under written contract with the health maintenance organization for the same covered service.

Calculation of rate – This provision applies to health care providers other than hospitals and trauma physicians. The Health Plan will calculate the average rate paid to similarly licensed providers under written contract with the health maintenance organization for the same covered service by summing the contracted rate for all occurrences of the Current Procedural Terminology Code for that service and then dividing by the total number of occurrences of the Current Procedural Terminology Code.

This is not a contract or a definitive statement of benefits. It is intended solely to provide you with an overview of the proposed Coventry benefits. Complete details of benefits, terms and exclusions are governed by your Coventry Group Membership Agreement (GMA). **The Coventry GMA may not cover all your health care expenses. Read your GMA carefully to determine which health care services are covered. If you have questions call us toll free at 1-800-833-7423.**